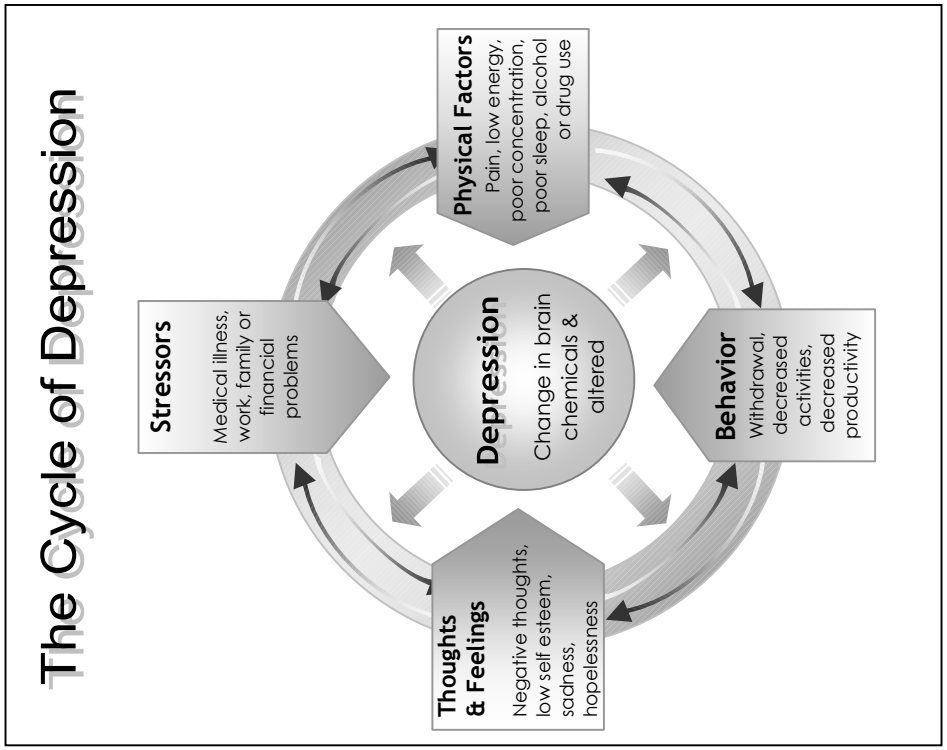


## Diagnostic Criteria* for Major Depression (DSM-IV)

Major depression is present when the patient has had at least **5 of the 9** symptoms listed below for *a minimum of two weeks*. **One of the symptoms must be either item 1 or 2.**

**1. Depressed mood**

**OR**

**2. Loss of interest or pleasure**

**3.** Significant change in weight or appetite

**4.** Insomnia or hypersomnia

**5.** Psychomotor agitation or retardation

**6.** Fatigue or loss of energy

**7.** Feelings of worthlessness or guilt

**8.** Impaired concentration or ability to make



* **Dysthymia** is present when the patient has had a chronic depressed mood that impairs function for at least 2 years. Dysthymia should be treated with medication and/or psychotherapy.

* **Minor depression** is present when the patient has had **2 to 4** of the 9 symptoms listed above for at least two weeks (*with one of the symptoms being either item 1 or 2*). Patients with minor depression should be educated and counseled about depression, then re-evaluated in 1 to 3 months, but do not require medication or full-course psychotherapy unless complicating features are present.

HSR&D Center for the Study of Health care Provider Behavior, VA Greater Los Angeles Healthcare System

Northwest Center for Outcomes Research in Older Adults, VA Puget Sound Healthcare System

For inquiries, visit our TIDES/WAVES website:
**www.va.gov/tides_waves/**

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The Cycle of Depression
Physical Factors
Pain, low energy, poor concentration, poor sleep, alcohol or drug use
Behavior
Withdrawal, decreased activities, decreased productivity
Thoughts & Feelings
Negative thoughts, low self esteem, sadness, hopelessness
Stressors
Medical illness, work, family or financial problems
Depression
Change in brain chemicals & altered

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# Depression Treatment Troubleshooting Guide

| PROBLEM* | MANAGEMENT |
|---|---|
| **Suicidal ideation** and/or history of prior suicide attempts. | ▪ Assess for dangerousness (e.g., plan, intent, means, current substance abuse, psychosis, agitation)<br>▪ Contract with patient for safety<br>▪ Develop co-management plan with Mental Health (MH) and Care Manager (CM)<br>▪ Limit number of pills – Use least toxic options (SSRIs) |
| **Psychotic symptoms**, e.g., delusions, hallucinations, disorganized speech and/or behavior. | ▪ R/O metabolic or neurologic disorder<br>▪ If unlikely organic, contact MH specialist |
| **Manic symptoms**, e.g., elevated mood, irritability, decreased sleep, increased energy, talkativeness or activity, poor judgment or impulsiveness. | ▪ Consider discontinuing anti-depressants as they may cause mania<br>▪ Screen for stimulant drug abuse<br>▪ Consider MH specialist referral and/or mood stabilizer – Patient may be bi-polar |
| **Intolerance to SSRIs and newer anti-depressants.** | **Consider**:<br>▪ Psychotherapy<br>▪ Tricyclic antidepressants<br>▪ Electro-Convulsive Therapy |
| Evidence of recent or ongoing **alcohol or drug abuse.** | ▪ Discuss with patient one month abstinence from drugs/alcohol prior to starting anti-depressants<br>▪ Consider stages of change approach to primary care management<br>▪ Consider referral to MH substance abuse treatment program |
| **Recent** past **history** of severe **psychiatric problems** or **hospitalizations**. | ▪ Check for evidence of MH care plan<br>▪ Develop psychiatric crisis co-management plan with MH |
| Persistent severe **psychosocial problems or stressors**, e.g., marital problems, homelessness, etc. | ▪ Refer patient to Social Work Service, Vet Center, local agencies that provide for basic needs<br>▪ Consider adding psychotherapy |

***** For all problems, consider consulting with Mental Health Liaison and Care Manager.



# Depression Treatment Medications Guide

| ANTI-DEPRESSANT | DAILY DOSAGE (in mg) Target/Max/65+ Start | SIDE EFFECTS | COMMENTS DO NOT USE ANY OF THESE DRUGS WITH MAOIs | |
|---|---|---|---|---|
| **TRICYCLICS** | | | | |
| **Desipramine** (Norpramin) | 75/250/25 Therapeutic drug level: 150-300 mgm per ml | Dry mouth, sedation, constipation, blurred vision, tachycardia, confusion, tremor, anticholinergic SEs. | May improve low energy, psychomotor retardation. | Avoid if pt. has conduction defect, MI, urinary retention, glaucoma. Useful for chronic pain. May inhibit beta blockers. |
| **Nortriptyline** (Pamelor) | 50/150/30 Strict therapeutic range: 50-150 mgm per ml | | May improve anxiety, insomnia. | |
| **SSRIs** | | | | |
| **Citalopram** (Celexa) | 20/ 40-60/ 20 | Sexual dysfunction, headaches, initial anxiety (first week), insomnia or sedation, tremor, nightmares, agitation, nausea and/or diarrhea (most likely with Sertraline). | Low inhibition of cytochrome P450, low drug-drug interaction. | Taper to avoid withdrawal. Combining serotonin agents, lithium, or L-tryptophan may cause serotonin syndrome. May decrease glucose, prolactin & digoxin levels & increase theophylline level. Increases half-life of tricyclics & benzodiazepines. |
| **Fluoxetine** (Prozac) | 20/ 40-80/ 10 | | Long half-life. | |
| **Paroxetine** (Paxil) | 20-30/ 40-60/ 10 | | May displace warfarin & increase PT levels. Long half-life. | |
| **Sertraline** (Zoloft) | 50-100/ 150-200/ 25 | | May displace warfarin & increase PT levels. Take with food. | |
| **OTHER AGENTS** | | | | |
| **BupropionSR** (Wellbutrin) | 150-300/ 450/ 50 1 dose maximum = 200 mg | Headache, restlessness, agitation, insomnia, decreased libido. | Effective for smoking cessation. Avoid in patients at risk for seizures or bulimia. Slow release (SR) better tolerated in depressed patients | |
| **Mirtazapine** (Remeron) | 15/ 45/ 7.5 | Dry mouth, dizziness, sedation, weight gain. | Low drug-drug interaction. | |
| **Nefazodone** (Serzone) | 200-400/ 600/ 100 BID dosing for all | Dry mouth, dizziness, sedation nausea. | Low sexual dysfunction. **Use with caution** – many significant drug-drug interactions; possible fatal interaction with some antihistamines. | |
| **Venlafaxine** (Effexor) | 75-150/ 225/ 50 | Nausea, activation, sweating, headache. | Increases diastolic BP - avoid in hypertensive patients. | |



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